National Conference of State Legislatures

STATE HEALTH NOTES

FORUM FOR STATE HEALTH POLICY LEADERSHIP

VOLUME 25, NUMBER 415

MARCH 8, 2004

What a Tangled Web: Hospital Billing and the Uninsured

Consuelo Flores is an uninsured American whose arm was crushed in a car accident during a trip to Mexico. Local doctors amputated what was left of her arm, and Flores returned home to **Colorado**. Experiencing inflammation and pain, she went to her local hospital and was briefly hospitalized. When the $47,000 bill arrived, Flores was stunned. The hospital offered her a 25 percent discount, to $34,600, and Flores tried to pay, maxing out three credit cards and taking out a second mortgage on her house. She lost her house to the bank.

Flores, who spoke at a press briefing on Capitol Hill organized by a patient advocacy group, had stumbled over one of health care's conundrums: that hospitals routinely give free care to the indigent, and they get discounted payments from Medicare, Medicaid and private insurers. But those who have some means and are uninsured - or "self pay" - at least initially get charged the full list price, which may be 20, 30 or even 50 percent more than the price charged to insurers.

In a series of articles over the past year, the *Wall Street Journal* documented that some hospitals were not only charging the uninsured the full list price, but were using aggressive collection tactics, such as seizing patients' bank accounts, garnishing their wages, placing liens on houses and having patients arrested for failure to attend a court hearing. Eighty percent of the uninsured are in working families, and two-thirds are in low-income families. The *Journal* articles opened a window into the incredibly complex and little-seen world of hospital financing, in which cross-subsidies are rampant and few charges are based on cost. Policymakers are now debating whether, and how, to make pricing policies more rational and transparent.

Should legislators require hospitals to charge the uninsured their lowest price? Should they strip non-profit hospitals that "overcharge" the uninsured of their tax-exempt status? Or would new laws and stricter enforcement of regulations only squeeze hospitals that are already fiscally stressed? Currently, a third of hospitals are operating in the red, according to the American Hospital Association (AHA). "The tendency is easy for legislators to say, 'We need hospitals to provide more charity care,'" said Kevin Barnett, senior investigator with the Public Health Institute in Oakland, **California**. But hospitals "are under enormous pressure and it's unrealistic to expect them to solve the problem of the uninsured when they have to negotiate low rates with payers and deal with the rising costs."

Nevertheless, the practice of charging the list price to the uninsured and then using aggressive tactics to get paid seems to have touched a collective nerve among the public and within government. "I'm usually a friend of the hospital industry," said Uwe Reinhardt, health economics professor at Princeton University. "But on this one, they should be ashamed. . .They should look the camera in the eye and say, 'I'm sorry.'"

"It's not as cut and dried as some critics would say," said Rick Wade, a senior vice president with the AHA. List prices serve as the platform from which managed-care organizations demand steep discounts, so hospitals have little choice but to set those prices high, he said.

STATES TAKE ACTION

It's obvious that expanding coverage would help both consumers and hospitals, said California Assemblymember Wilma Chan. "But reform is a very complex issue. There will always be some who are uninsured (and who will depend on hospitals to be their safety net). We need to look at the overall costs of health care, and what's driving them up, and find ways to help hospitals deal with them." In the meantime, she said, "health-care costs are the second highest cause of bankruptcy. The (issue of patient debt) is a very immediate problem that is causing average people to lose their life savings. We need to do something about it right away."

[Billing, p.2]

IN THIS ISSUE

PUBLIC HEALTH NEWS

State Health Notes is supported in part by a grant from the Robert Wood Johnson Foundation.

Billing, from p. 1

Chan has introduced a bill that would require every hospital to develop policies for self-pay patients; charges could not exceed the prices paid for the same services by Medi-Cal, Medicare or workers' compensation insurance. Hospitals would have to counsel patients about their eligibility for Medi-Cal or charity care, wait 180 days before beginning collection activities, and use "reasonable efforts" to negotiate a payment plan with a patient before selling the patient's debt to a third party.

In 2003, **Connecticut** enacted a law that standardizes hospital debt collection practices, prohibits debt collection activities until a patient's eligibility for aid has been assessed and transfers to the hospital the court costs that used to lie with the patient. The law also reduces the amount that a hospital can claim as judgment interest, limits the ability of a hospital to sue spouses for unpaid debt and discourages wage attachments and liens.

In **Florida**, the Legislature is considering a bill, backed by the Florida Hospital Association, that would require hospitals to give at least a 30 percent discount to uninsured persons earning less than three times the federal poverty level ($55,000 for a family of four). Patients could not be eligible for insurance, and could not have discretionary assets in excess of 50 percent of billed charges.

"The bill will go a long way in helping those persons who are uninsured in South Florida," bill sponsor Rep. Marcelo Llorente told the *Miami Herald*. But the proposal was slammed by K.B. Forbes, head of the **Washington, D.C.**-based advocacy group Consejo de Latinos Unidos. Forbes said studies show that managed-care plans generally pay only one-fifth to one-third of list prices. Uninsured persons shouldn't have to pay more than managed-care plans, Forbes said.

ILLINOIS PLAYS HARD-BALL

The issue gets particularly heated when it involves non-profit hospitals, which are almost universally granted exemptions from federal and state income taxes, and local property taxes — in exchange for providing some "community benefit."

In February, the **Illinois** Department of Revenue revoked the tax-exempt status of Provena Covenant Medical Center, a Catholic-affiliated non-profit facility in Urbana.

The department acted after local tax authorities determined that the hospital had used aggressive debt-collection tactics to seek payment from uninsured patients. Officials also were concerned that the hospital had contracted with outside entities to provide services, such as pharmacy management and emergency room physician services. That raised the issue of whether for-profit groups were benefitting from the hospital's non-profit status.

Ironically, the state acted after Provina CEO Mark Wiener had greatly increased the amount of charity care provided to low-income patients and softened collection tactics, in response to pressure from a local patient advocacy group. The hospital has appealed the ruling - but if it stands, the hospital will have to pay the county approximately $1 million for property taxes owed in 2003.

The AHA's Wade said he wouldn't be surprised if other governments started scrutinizing the non-profit status of local hospitals. "The local government [in Urbana], like local governments everywhere, is strapped for cash," Wade said. "And it's pretty unpopular to raise taxes right now."

But he warns that stripping a hospital of its tax-exemption without considering the ramifications on the uninsured is like pulling a string on a sweater. "If a local government begins taxing a non-profit hospital, will the government then step up and be responsible for charity care?" Wade asked. "Or, by taxing it, are you debilitating the ability of the hospital to deliver care?"

Most hospital reimbursement is fixed in the form of prospective payments from Medicare and Medicaid. In a 2003 white paper, the consulting firm Cleverley & Associates notes that only 10 to 25 percent of a hospital's business is charge-related; this includes discounted charges to managed-care organizations and charges to the self-pay. Even so, increasing charges by only 10 percent can have an enormous effect on a hospital's bottom line, doubling operating profits and margins.

Even so, obtaining a profit in today's health-care environment is difficult, the firm said. For example, a hospital may need to receive $5,400 per discharge to cover its costs and get a return on investment of $4 million. The fixed-fee payers pay less than costs, which means that payers who are charged must bear an additional $2 million in fees. The hospital needs to earn $5,400 per discharge, but recovers only $4,764.71 from fixed-fee payers, requiring a $9,000 payment from payers who are charged. This figure is inflated to $11,250 when the average write-off or discount to charged payers of 20 percent is figured in.

"The results in this example are painfully obvious to every hospital executive," wrote William Cleverley, president of the firm. "Hospitals who lose money on Medicare and managed care contracts must raise rates sharply to a limited charge-related payer base" - which includes the self pay.

The hospital industry says that it doesn't need more regulation, that it will voluntarily work with the uninsured on billing issues. In 2003, both the AHA and the giant for-profit Tenet Healthcare Corporation adopted guidelines urging hospitals to provide financial counseling to the uninsured and to back off from aggressive collection efforts. Both stopped short of doing what patient advocates want — that is, of saying that hospitals should charge the uninsured their lowest prices.

Before they could do that, both organizations said, they would have to get clearance from the U.S. Department of Health and Human Services (HHS) that giving such discounts was legal. The hospitals were concerned that federal rules require that they not discriminate between Medicare and privately insured patients. In February, HHS Secretary Tommy Thompson sent a letter to the AHA, stating that hospitals can give discounts to the uninsured and underinsured without fear of prosecution.

As *SHN* went to press, the AHA had said that the Thompson letter was helpful, but that it raised "additional questions." Tenet, meanwhile, has decided that its hospitals will give discounts to the uninsured.

NO EASY ANSWERS

"We have to face up to it, that there are some deadbeats out there who have the ability to pay and don't," said Dr. Paul Hattis, professor at Tufts University Medical School. "But hospitals ought to have better processes to determine up-front who has the ability to pay and who doesn't."

If anything good comes ought of this whole controversy, Hattis added, it will be that the whole system of health-care costs and charges will become more transparent. "It's crazy that hospital bills have nothing to do with the costs, and it's crazy that the uninsured get charged the highest bills," he said.

✦ *CK*

PUBLIC HEALTH *NEWS*

Linking the Environment to Racial and Ethnic Health Disparities

John and Gina have suffered an asthma attack. Both children are 12 years old, but Gina is three times more likely than John to be hospitalized for the bout. What accounts for Gina's increased risk? It can be explained in large part by her race. Gina is black. John is white.

Across the U.S., state legislators and others who bear responsibility for public health are tackling the striking racial and ethnic disparities that exist in the prevalence of chronic diseases, such as asthma, heart disease, and breast and cervical cancer.

Consider these facts: according to a recent report by the U.S. Centers for Disease Control and Prevention (CDC), the rate of diabetes is two to three times higher for American Indians and Alaskan Natives than for all racial and ethnic populations combined. The Trust for America's Health reports that African-Americans have the highest incidence of cancer and are more likely to die from the disease than are other groups. And U.S.-born Hispanics have a greater risk of cancer than Hispanics who live in the same neighborhood, but were born in foreign countries.

Determined to close the disparities gap, state and federal policymakers are partnering with local stakeholders, including residents, businesses, the public health system and community-based organizations. Many of these efforts focus on the environmental stresses that are particularly prevalent in economically disadvantaged areas. By addressing and increasing public awareness of environmental concerns, these partnerships may hold the key to closing the gap between low-risk populations and those that are at increased risk for chronic diseases.

But the policymakers face serious obstacles. In its 1999 report *Toward Environmental Justice: Research, Education and Health Policy Needs*, the Institute of Medicine (IOM) concluded that communities with disproportionately high levels of toxicants, light, noise, odors and particulate matter may be at increased risk for disease.

For example, in conducting research for the report, the IOM interviewed residents of Nogales, Arizona, a low-income, primarily Hispanic/Latino community whose residents were exposed to air pollutants from manufacturing plants across the border in Mexico. The IOM investigators found unusually high rates of multiple myeloma, a form of cancer, and lupus. Industrial sites and industries that may cause pollution are more likely to be located in neighborhoods of lower socioeconomic level (such as Nogales) than they are in high-income neighborhoods.

Environmental pollutants contribute to some disparities in chronic disease – but other community-level conditions associated with lower socioeconomic status often play a role. In these instances income level may explain differences among groups as well as, if not better than, race or ethnicity.

Dr. Robert Fullilove, associate dean for community and minority affairs at Columbia University, has researched the increased risk of diseases such as HIV and asthma in Harlem. "Where you reside has as much to do with health risks as race," he explained. "When there is a significant lack of investment in schools and a whole host of city services, the have-nots are over-represented in prisons and hospitals."

In the case of asthma, for example, poverty, substandard housing, inadequate access to health care, lack of education, and failure to adequately control asthma with medication all contribute to asthma episodes and deaths, according to the Alliance for Healthy Homes.

Dr. Fullilove has advice for legislators who want to target these communities: "There's one classic lesson. These are all communities that have experienced serious decline in quality of life. . .Focus on these communities and ask what services are missing that are routinely available in well-off areas."

Underprivileged communities may experience higher levels of poor nutrition and lack of exercise, which the CDC says may lead to type 2 diabetes, hypertension, heart disease, stroke, some cancers, gallbladder disease and arthritis. Lack of playgrounds, open space and grocery stores with nutritious foods may exacerbate conditions in urban areas.

Dr. James Marks, director of the CDC's National Center for Chronic Disease Prevention and Health Promotion, explains why this problem is also a concern for the nation. "Chronic diseases such as heart disease and stroke, which will cost the United States a projected $368 billion in 2004, often affect minorities in low-income urban and rural areas disproportionately," he said. "CDC works with communities across the country to encourage healthy lifestyles to reduce the burden of these diseases on our economy and health system."

REACHING FOR HEALTH

The CDC hopes to surmount some of these hurdles through the Racial and Ethnic Approaches to Community Health (REACH 2010) program. This federal-state-local partnership supports the efforts of community coalitions to eliminate health disparities among minority populations. The CDC currently funds 40 REACH projects in 21 states.

One project, the REACH Detroit Partnership, administered by the Community Health and Social Services Center Inc., in Detroit, Michigan, informs, educates and empowers families, communities and healthcare providers to better manage diabetes and prevent occurrences by building relation-

[Environment, p.6]

PUBLIC HEALTH *NEWS*

is produced by staff from the Environment, Energy and Transportation Programs and the Health Care and Prevention Projects Programs, located at the National Conference of State Legislatures headquarters in Denver.

For more information about the programs, visit: http://www.ncsl.org or call (303) 364-7700.

CONTRIBUTING STAFF

Glen Andersen, Steve Christian, Allison Cook, Carla Curran, Jo Donlin, Doug Farquhar, Shannon Harper, Tracey Hooker, Martha King, Jeane Kaurman, Leslie Teach Robbins, Hy Gia Park, Jody Ruskamp, Lisa Speissegger, Laura Tobler, Stephanie Wasserman, Nina William-Mbengue, Amy Winterfield

700East First Place
Denver, CO 80230
Fax: (303) 364-7800
email: tracey.hooker@ncsl.org or martha.king@ncsl.org

This insert is supported in part by grants from the Centers for Disease Control and Prevention and the Health Resources and Services Administration, U.S. Department of Health and Human Services

HEALTHTALK

BURKE: LINKING THE ENVIRONMENT TO HEALTH DISPARITIES

Thomas A. Burke is one of the nation's leaders in exploring the link between the environment and public health. A professor and associate chair at the Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management, he has joint appointments in the Department of Environmental Health Sciences and the School of Medicine's Department of Oncology. As principal investigator for the Pew Environmental Health Commission, Burke helped to establish the framework for a national approach to environmental public health tracking. Prior to his appointment at Johns Hopkins, Burke was deputy commissioner of health for the State of New Jersey and was director of the Office of Science and Research in the New Jersey Department of Environmental Protection.

Q: What role does the environment play in causing health disparities?

A: The environment really plays a role in everyone's health status. It can be broadly defined as housing, the built environment, and more narrowly defined as the kind of exposures that we get in the environment. We know from the earliest days of public health that the quality of the air, the quality of the drinking water and the quality of the housing are enormous determinants of the health of a community. The environment plays an enormous role not just in health disparities but also in community health.

Q: What environmental factors are most important?

A: If you take a look at the health of our communities nationwide, [you can see] that there are lots of social and behavioral factors that contribute to the indicators of community health.

Urban environments and environments where there are high concentrations of poor people, who may not have access to medical care, have poorer health indicators. These also happen to be the places where environmental quality has been challenged – because of historical industrialization, because of urban design, and because of concentrations of [car exhaust] and other related pollutants.

If you look at a national map of areas that have not met the standards of the Clean Air Act, you'll find that the areas that are hit hardest are the urban ones. Now that's not just minorities or people who are economically disadvantaged, but all the folks in those areas.

Still, the health indicators are the worst for those who have the least access (to health care) and are therefore more vulnerable to the environmental contaminants. I think it's an important consideration in any prevention strategy that we focus our efforts on those who are at highest risk.

A: Which health disparities cause the most concern?

Q: Obviously a lot of disparities cut to very important social issues. However, there are also very important aspects of disparities that are environmental. If you look at the major causes of morbidity and mortality – heart disease, respiratory disease, even infectious disease to some degree – there are very important environmental components. In addition, there are a number of health conditions that we are becoming more aware of, including neurological and developmental issues, issues such as attention deficit and immune disorders, that again hit the disadvantaged hard. The role of the environment in these disparities is important.

Q: Is it simply a matter of economics and income, or is there another reason for these disparities?

A: I don't think you can separate the two. Unfortunately, those who are the most disadvantaged throughout our country bear the biggest burden of pollution. Look at where the garbage dumps are, where the superfund sites are, where the heavy industries are, where the obnoxious kinds of industries like rendering plants are. They don't happen in the wealthy suburban areas.

Our environmental decision-making really hasn't included full consideration of health effects. If you look at our waterways and where the toxic contamintation of fish is highest, it's in our urban areas, where the industrialization has been most intense. If you look at where our sewage treatment plants are out of compliance, it's again in our urban areas.

The treatment and disposal of waste affects both rural and urban areas. Political clout and economic opportunity play a role in who is exposed, and in who is able to affect the environmental decision-making process.

Q: What can be done to reduce environmentally related health disparities?

A: There are several really important new aspects of what is going on in environmental health, and one is a recognition that public health is an aspect of environmental decision-making.

One of the most influential new programs is the National Environmental Public Health Tracking Program initiated by the National Center for Environmental Health at the CDC, over the last two years. This program has taken a hard look at almost half of the states now and at several major municipalities. . .It looks at health patterns that are related to the environment, and at sources of exposure (to pollutants). It is moving us toward a much better understanding of exposure.

I think there are a lot of missing links in this area. For instance, we can see that the highest toll for certain cancers that may be related to the environment is in our urban areas and in areas where there are disparities. The same is true for certain respiratory diseases and for overall mortality. However, we really haven't filled in the blanks in understanding exposure.

One question in most environmental justice cases is: is this community exposed to things that are harmful to its health? Now we are developing new tools that can look at levels of contaminants within the human body and can address some of these fundamental questions. Right now I think there are tremendous gaps in our understanding. National environmental laws are not set up to take into account the issues of environmental justice and community health disparities, and disparities in exposure and environmental risk.

Q: What is the role for state policymakers in this area?

A: We're on the threshold of a new era for the states to take a leadership role in looking at some fundamental issues of zoning and environmental decision-making. The states can ask the critical questions: How does public health enter into the equation? Shouldn't the health of a community be part of the equation when making environmental decisions – whether it's the siting of a new source of pollution or investing in better pollution control or in the design of an environment that would be safe and habitable, perhaps by reducing traffic density and pollutants?

I think that an awful lot of the social, economic, behavioral and environmental factors that come together to determine community health are now being recognized as we move forward to address the issues of zoning, the built environment and creating healthy communities. *GA*

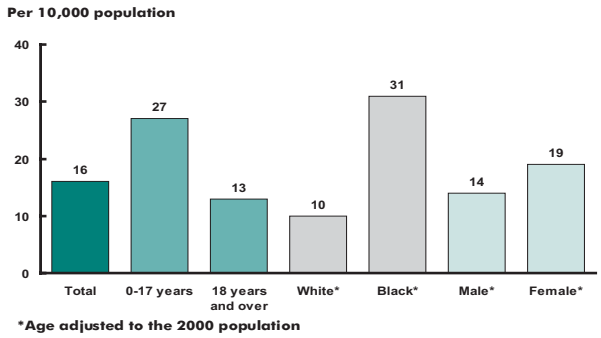
Health Disparities and the Environment

Deaths Due to Five Leading Chronic Disease Killers as a Percentage of all Deaths, United States, 2001

Cause of Death	Number of Deaths	Percent
Five Leading Chronic Disease Killers	**1,611,833**	**66.7**
Diseases of the Heart	700,142	29.0
All Cancers	553,768	22.9
Stroke	163,538	6.8
Chronic obstructive pulmonary	123,013	5.1
Diabetes	71,372	3.0
Other	804,592	33.3
Total	**2,416,425**	**100.0**

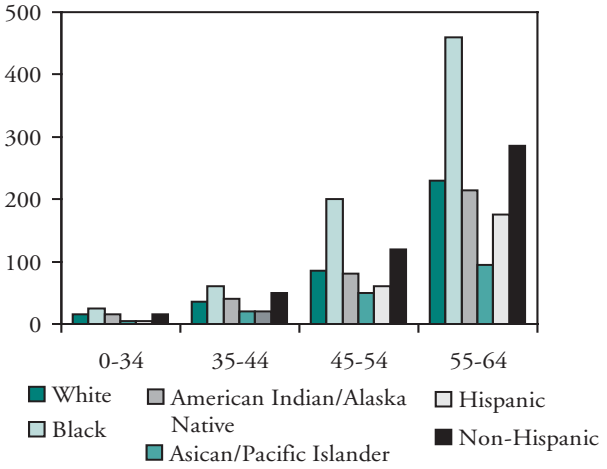
Source: Centers for Disease Control and Prevention, 2004

Asthma Hospitalizations 2001



Source: National Center for Health Statistics, 2004

Heart Disease Death Rates per 100,000, by race/ethnicity and age group



Source: Morbidity and Mortality Weekly, Centers for Disease Control and Prevention, Feb. 2004

Environment, from p. 3

ships, support groups and community-wide environmental changes.

Some of these environmental changes include the growth and cultivation of community gardens in two plots of land in Southwest Detroit, the start of four new neighborhood fruit and vegetable mini-markets, and numerous "Healthy Soul and Latino Cooking" demonstrations and classes.

Another REACH 2010 project, the Kansas City Chronic Disease Coalition (KC-CDC), managed by the Missouri Primary Care Association, also works to create environmental conditions that promote widespread behavioral changes. The aim is to improve the health outcomes associated with the high prevalence of diabetes and cardiovascular disease among African-American and Hispanic populations in Kansas City, Missouri.

The Coalition – in partnership with state and local health departments, neighborhood associations, and community and faith-based organizations – has implemented a "30/Thirty" Health Walks Program, a compilation of maps of 30 safe walking tours. The KC-CDC also has created a "Healthy Habits" program, which uses various environmental and organizational approaches to improve health outcomes among minority populations. For example, food suppliers are urged to promote healthy nutrition, access to health care has been increased by creation of a mobile health facility, media campaigns are used to increase the awareness of health risks, and healthy behaviors are advanced through social services programs.

The CDC's National Asthma Control Program also aims to reduce disparities by tracking and analyzing asthma data, recommending appropriate public health interventions and partnering with federal agencies, universities and other stakeholders. In FY 2003, the CDC funded asthma control projects in 37 states. These activities seek to reduce deaths, hospitalizations, emergency room visits, school and work absences and limitations on activity caused by asthma.

The federal government also investigates the role of the environment in chronic disease health disparities. The National Institute of Environmental Health Sciences (NIEHS) of the National Institutes of Health (NIH) performs research and provides grants for studies that explore how toxic exposures affect disadvantaged populations. Current NIEHS-funded activities range from research on occupational exposure to toxic substances among Hispanic meat packers, to environmental factors that may lead to end-stage renal disease, particularly in African-Americans.

STATES TAKE ACTION

Many states also are taking it upon themselves to tackle disparities in health. As of August 2003, thirty-four states had established offices of minority health through legislative or executive action. These state minority health offices often work to reduce barriers to care in communities, and they may undertake to improve the quality of health care that is available, which may in turn decrease rates of chronic disease.

Several states have taken additional steps. Minnesota launched its Eliminating Health Disparities Initiative (EHDI) in 2001. The initiative provides $9.5 million dollars in grants to local or regional projects that will reduce racial and ethnic disparities in chronic diseases and address other needs such as infant mortality. One EHDI-funded project seeks to decrease cardiovascular disease and diabetes in American Indians by increasing physical activity and improving nutrition.

Florida has a similar program created under the Closing the Gap Act, passed by the state Legislature in 2000. Closing the Gap provides grants to community-based organizations, county health departments and other groups that work to eliminate health disparities in chronic diseases such as cancer and diabetes by improving access to care and health outcomes.

In the 2001-2002 session, California legislators passed a measure aimed at creating a state Environmental Health Surveillance System that will track environmental exposures and diseases, with a focus on prevalence and determinants of chronic diseases. Sen. Martha Escutia, who represents the heavily Latino 50th Assembly District in southeast Los Angeles County and sponsored the legislation, has witnessed first-hand the impact that environmental hazards can have on the health of a community at risk.

"Many children in my district live near freeways and play in schoolyards adjacent to industries that use hazardous materials," she said. "I listened as teachers at a junior high school reported a high number of miscarriages among the faculty and heard parents complain about their children having a history of illnesses at that school, which happened to be surrounded by two chromium-plating factories."

The legislation created a working group that includes "experts with knowledge of the sensitivity and exposure of children, women of child-bearing age, seniors, and disparately affected populations to environmental hazards" to make recommendations regarding the surveillance system. The working group's first report released in February 2004 estimated that Californians pay over $10 billion per year for nine environmentally-related chronic diseases, including asthma, cancer and lead poisoning. The report also found that reducing those nine environmentally related diseases by 1% could save Californians $100 million annually.

The policy research center at the University of California responsible for the report acknowledged that this venture would require a team effort – a theme common to all of the projects explored in this article. *AJ*

ADDITIONAL RESOURCES:

CDC Asthma Control Program: *www.cdc.gov/asthma*

CDC Racial and Ethnic Populations Page: *www.cdc.gov/omh/Populations/populations.htm*

CDC REACH 2010 Program: *www.cdc.gov/reach2010*

STATE HEALTH *NOTES*
FORUM FOR STATE HEALTH POLICY LEADERSHIP

Published biweekly (24 issues/yr.) by the FORUM FOR STATE HEALTH POLICY LEADERSHIP, an information and research center at the National Conference of State Legislatures in Washington, D.C.

For more information about Forum projects, visit our Web site at: www.ncsl.org/programs/health/forum

RESEARCH & EDITORIAL STAFF
Dick Merritt — Forum Director
Christina Kent — Managing Editor
Anna C. Spencer — Associate Editor
Contributors: Allison Colker, Donna Folkemer, Wendy Fox-Grage, Shelly Gehshan, Tim Henderson, Michelle Herman, Diana Hinton, Kala Ladenheim, Greg Martin, Anna B. Scanlon

EDITORIAL INQUIRIES
Christina Kent, Managing Editor
Tel: 202-624-5400 • Fax: 202-737-1069
email: christina.kent@ncsl.org

ADVISORY BOARD
Rep. Fran Bradley, Minnesota
Rep. Charlie Brown, Indiana
Rep. Dianne White Delisi, Texas
Kurt DeWeese, Speaker's staff, Illinois
Rep. Peter Ginaitt, Rhode Island
Del. Marilyn Goldwater, Maryland
Sen. Kemp Hannon, New York
John Kasprak, Senior Attorney, Connecticut Legislature
Sen. William Martin, North Carolina
Sen. Pat Thibaudeau, Washington
Sen. Maggie Tinsman, Iowa

HEALTH POLICY TRACKING SERVICE
M. Lee Dixon — HPTS Director
Staff: Patrick Johnson, Andrew McKinley, Carla Plaza, Rachel Tanner

CUSTOMER SERVICE & SUBSCRIPTIONS
NCSL, 7700 East First Place, Denver, CO 80230
Tel: 303-364-7700 • Fax: 303-364-7800

HIGHLIGHTS

MEDICAID

Federal Review

At a Feb. 22 National Governors Association meeting, U.S. Health and Human Services Secretary Tommy Thompson announced that the federal government plans to review Medicaid financing rules in order to stem federal Medicaid expenditures. The review is an attempt to rein in creative bookkeeping practices employed by states to obtain additional federal matching funds. Thompson noted that implementing new rules could save the federal government $1.5 billion in FY 2005 and $23.6 billion over the next decade.

Last month, states were notified that the federal government plans to require states to provide detailed descriptions of each source of revenue used to pay their shares of the cost of Medicaid. Under the new rules, the federal government would also have to approve state Medicaid budgets, and states will not be eligible for federal funds for additional costs until the expenditures have been approved by federal officials. According to a Feb. 22 *New York Times* article, the proposed changes have "tipped off an uproar among states" who argue that "soaring Medicaid costs" and less than expected revenue collections have put them in a "fiscal vise."

PUBLIC HEALTH

Women, Minorities at Risk

HIV/AIDS is increasingly a heterosexually acquired disease of women and African-Americans. The Centers for Disease Control and Prevention analyzed data from 1999-2002 in the 29 states that have tracked HIV status by name for more than four years. Researchers found that 35 percent of all new HIV cases were heterosexually acquired; 64 percent of those cases occurred in females, and 74 percent occurred in non-Hispanic blacks. Eighty-nine percent of the females who acquired HIV through heterosexual sex were only 13-19 years old.

The CDC notes that those young women may be having sexual contact with older men, who are more liklely to be infected. Non-Hispanic black and Hispanic populations make up only 21 percent of the total population of the 29 studied states – but those populations accounted for 84 percent of the heterosexually acquired HIV infections during the study period. To reduce that disparity and the number of new infections, the CDC recommends that barriers to HIV care and prevention services be removed, and that culturally targeted education and prevention programs be put in place. For more, see the Feb. 20 *Morbidity and Mortality Weekly Report*.

PHARMACEUTICALS

Importation Study

The Bush Administration announced Feb. 25 that it plans to conduct a year-long study on the safety of importing prescription drugs from Canada. The study, required by the new Medicare law, will be overseen by the head of the Food and Drug Administration, currently Dr. Mark McClellan. McClellan has adamantly opposed reimporting drugs from Canada, and his agency has threatened legal action against cities and states that are helping their citizens do so. According to U.S. Health and Human Services Secretary Tommy Thompson, the committee will hear testimony from governors and federal lawmakers on both sides of the issue.

PROVIDER ISSUES

Overtime Laws

Hoping to improve patient safety and reduce medical errors, two governors recently signed laws limiting the number of hours health care workers are required to work:

✦**New Jersey** has a new law on the books banning forced overtime for health-care staff. Signed by Gov. James McGreevey on Feb. 24, the new law applies to all hourly employees who provide patient care or clinical services, including therapists, pharmacists, nurses, nursing aides and technicians who perform tests, but not physicians. Nurses and union officials say the new law will improve patient safety, reduce medical mistakes and help reduce staffing shortages by improving working conditions.

The New Jersey Hospital Association, on the other hand, says it will be hard to comply with the law because of fluctuating patient loads and demands. The rule is suspended in the event of an unforeseeable emergency event, or in the case of a national or state emergency. However, in these situations, hospitals and nursing facilities may require personnel to remain at work, provided the facilities make a reasonable effort to find volunteer and per-diem replacement nurses. Facilities that violate the law are subject to $1,000 fines for every day that they are not in compliance.

✦On Feb. 25, **West Virginia** Gov. Bob Wise signed a measure barring private hospitals from forcing nurses to work overtime, except in emergencies or to complete a patient procedure. Wise echoed health-care and union officials by saying the law would improve patient safety and prevent medical mistakes by nurses exhausted by long hours. Beginning May 17, nurses who work more than 12 hours must be given 8 hours off. The law will cover an estimated 10,100 nurses at West Virginia's 60 private hospitals. Four state-run hospitals and four veterans' hospitals run by the federal government are unaffected.

New Jersey and West Virginia join **Washington** as the only three states to regulate overtime hours for health-care staff.

FOR YOUR *INFORMATION*

Coordinating Care Yields Savings in Minnesota

Minnesota has found a way to deliver effective, seamless care to one of the most difficult-to-treat patient populations: those with chronic and complex conditions. The Minnesota Disability Health Options Project (MnDHO) has not only gotten high ratings from its enrollees, but slashed their hospitalization rates.

The MnDHO was created in an effort to improve service delivery for people with chronic and complex conditions. Most public and private insurance programs focus on diagnosing and treating acute health-care conditions. Care for those with chronic conditions tends to be episodic, rather than well-supported and structured. The lack of oversight and coordination produces fragmented specialty care and too little primary care, resulting in costs that could have been avoided.

Medicaid programs have an enormous incentive to reduce their costs by providing seamless care. One-quarter of the approximately 25 million disabled people under the age of 65 are beneficiaries of Medicare (7 million) or Medicaid (1.3 million). Many are "dual eligibles" – they are disabled and indigent and are enrolled in both programs.

In an effort to eliminate service gaps, the Minnesota Department of Human Services created the MnDHO. The program is a partnership with UCare Minnesota Health Plan, a Medicaid and Medicare+ Choice plan, and AXIS Healthcare, which provides expertise in health-care coordination and case management for individuals with disabilities.

Modeled after the state's Social Health Maintenance Organizations, which contracted with the Centers for Medicare & Medicaid Services to coordinate Medicare benefits, MnDHO "incorporates an integrated service delivery model, and combines Medicaid and Medicare funding sources," said Pam Parker, director of integrated purchasing and demonstrations at the Minnesota Department of Human Services.

Medicaid beneficiaries (and dual eligibles) are qualified to participate in MnDHO. After comprehensively assessing applicants, the Department of Human Services and UCare awards a capitation contract to AXIS Healthcare, which then directs the delivery of all care services, provider relations and membership services.

Together with patients, AXIS care coordinators devise individualized health plans that strive to "maintain an individual's ability to live as independently as possible, while assuring that appropriate support services are available when needed," says Chris Duff, CEO of AXIS Healthcare. "We're about providing the right care at the right time" so that minor conditions don't escalate into situations that result in hospitalizations.

The partnership between the patient and the care coordinator in devising a health plan also "encourages enrollees to play a more active, informed role in their health care," he added. One of the driving principles of MnDHO is self-directed care, which gives enrollees the maximum level of choice and autonomy over the direction of their health care.

Since its inception in September 2001, 300 working-age Medicaid-eligible individuals with physical disabilities have voluntarily enrolled in the program. By 2005, MnDHO hopes to have 1,000 new members on board; the Department of Health Services also is hoping to expand this model to individuals with developmental disabilities.

An evaluation has demonstrated some positive findings, most notably in patient satisfaction. Ninety percent of patients report being satisfied with their health care services, and approximately 80 percent of enrollees rated their interactions with providers as very good or excellent. Eighty-five percent of patients reported receiving help managing their care, and the vast majority said they were satisfied with their level of involvement in decision- making about their care.

The evaluation also shows that hospitalizations have been more than halved, compared to the period prior to enrollment, and hospital lengths of stay have been reduced by more than 60 percent.

To provide the best model of care, it's necessary to look at primary- and acute- care services in conjunction with long-term care issues, said Parker. This integrated approach to service delivery enables providers to "look at patients across time," presenting opportunities for efficiency and improvement. *ACS*

For more, visit http://www.chcs.org/spotlight/2004January.html

STATE HEALTH *NOTES*
FORUM FOR STATE HEALTH POLICY LEADERSHIP
National Conference of State Legislatures
444 North Capitol Street, NW, Suite 515
Washington, D.C. 20001